DISSOCIATION AND SCHIZOPHRENIA: AN HISTORICAL REVIEW OF CONCEPTUAL DEVELOPMENT AND RELEVANT TREATMENT APPROACHES

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ABSTRACT

This paper provides an historical perspective regarding the role of dissociation in the development of both etiologic theory and treatment paradigms for schizophrenia. References to the concept of dissociation are drawn from classic writings on dementia praecox, and from Bleuler's (1911) original conception of schizophrenia as a "splitting" of the personality. An accurate diagnostic distinction between schizophrenia and dissociative disorders, such as dissociative identity disorder (DID) and brief reactive psychosis (BRP), often has been difficult to ascertain due to the presence of Schneiderian First-Rank Symptoms (FRS) in both types of disorders. The traditional Schneiderian FRS, once thought to be indicative symptoms of schizophrenia, now are viewed as characteristic diagnostic indicators of DID. Research and theory pertaining to differential diagnosis between schizophrenia and trauma-related dissociative syndromes are reviewed. Early psychodynamic treatment paradigms for schizophrenia and contemporary treatment paradigms for dissociative disorders are compared. Relevant diagnostic and treatment implications for the field of dissociative disorders are emphasized.

INTRODUCTION

Dissociative identity disorder (DID), known as multiple personality disorder in *DSM-III-R* (American Psychiatric Association, 1987), is a clinical syndrome which first gained recognition in the early nineteenth century (Bliss, 1980; Ellenberger, 1970; Greaves, 1980; Taylor & Martin, 1944). Interest in DID continued to develop throughout the latter half of the nineteenth century and the early twentieth century. A growing number of DID cases were reported in the clinical literature during this period (Ellenberger, 1970; Putnam, 1989; Ross, 1989; Sutcliffe & Jones, 1962; Taylor & Martin, 1944). However, this growth trend was short-lived. Professional interest in the field of dissociation eventually began to wane (Ellenberger, 1970; Rosenbaum, 1980; Rosenbaum & Weaver, 1980). Rosenbaum (1980) speculates that declining interest in DID can be correlated positively with Bleuler's introduction of the term "schizophrenia" in 1911. Rosenbaum also suggests that the over-inclusiveness of Bleuler's conceptual framework has contributed to difficulties in the differential diagnosis between DID and schizophrenia and to a growing trend of misdiagnosis, in which many individuals suffering from DID have been misdiagnosed as schizophrenic. Rosenbaum quotes the following passage by F.X. Dercum in support of his criticisms:

> Because of his interpretation of dementia praecox as a cleavage or fissuration of the psychic functions Bleuler has invented and proposed the name "schizophrenia" which he believes to be preferable to dementia praecox. However, as we have seen, cleavages and fissuration of the personality are not confined to dementia praecox. They occur *in many forms of mental disease as well as in the neuroses.* In my judgement [sic] the term being of *such general significance* offers no advantages over dementia praecox and should be rejected.
> (Dercum, cited in Rosenbaum, 1980, pp. 1384-1385)

A number of authors cite research findings in support of this view (Bliss, 1980; Boon & Draijer, 1993; Kluft, 1987; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989; and Ross et al., 1990). North American research findings indicate that between 25.6% to 49% of DID patients have received a prior diagnosis of schizophrenia (Putnam et al, 1986; Ross et al., 1989; Ross et al., 1990). In the Netherlands, Boon and Draijer (1993) determined that 15.6% of their 71-patient DID sample had received a prior diagnosis of schizophrenia. Boon and Draijer qualify these relatively modest statistical findings with the observation that schizophrenia traditionally has been diagnosed with less frequency in the Netherlands than it has been in North America.

Ross et al. (1994) offer the following commentary regarding the research findings cited above: "From these studies it is evident that *DSM-III-R* criteria for schizophrenia result in a false-positive diagnosis of schizophrenia in about one third of MPD patients. This is a major level of incorrect diagnosis with profound treatment implications" (p.5).

DISSOCIATION AND SCHNEIDERIAN FIRST-RANK SYMPTOMS

Several authors suggest that the common presence of Schneiderian first-rank symptoms (FRSs) in patients with dissociative identity disorder is a prime factor contributing to an inadequate differential distinction between the syndromes of DID and schizophrenia (Bliss, 1980; Boon & Draijer, 1993; Coons & Milstein, 1986; Fink & Golinkoff, 1990; Kluft, 1987; Putnam et al., 1986; Ross et al., 1989; and Ross et al., 1990).

Schneider originally defined the First-Rank Symptoms (FRSs) of schizophrenia as phenomenological indicators of the disorder in the following manner:

> Audible thoughts; voices heard arguing; voices heard commenting on one's actions; the experience of influences playing on the body (somatic passivity experiences); thought-withdrawal and other interferences with thought; delusional perceptions and all feelings, impulses (drives) and volitional acts that are experienced by the patient as the work or influence of others. When any of these modes of experience is undeniably present and no basic somatic illness can be found, we may make the decisive clinical diagnosis of schizophrenia. (Schneider, 1939, pp. 133-134)

The traditional Schneiderian FRSs, once thought to be indicative symptoms of schizophrenia, currently are viewed as diagnostic indicators of DID (Kluft, 1987). The presence of Schneiderian FRSs also has been established in connection with several other clinical syndromes (Andreason & Akiskal, 1983; Carpenter, Strauss, & Mulch, 1973).

Kluft (1987) reports that 100% of a 303-patient DID sample endorsed the presence of Schneiderian FRSs, with a mean FRS index of 3.6 per patient. In a similar study, Ross et al. (1989) used a sample of 236 DID patients, and obtained a mean FRS index of 4.5 per patient. A replication study by Ross et al. (1990) yielded a mean FRSs index of 6.4, in a series of 102 patients. Additionally, Fink and Golinkoff (1990) have reported that 94% of their 16-patient DID sample positively endorsed one or more Schneiderian FRS, with a mean FRS index of 4.8. The latter authors also report findings from a comparison study involving 11 schizophrenic patients, which yielded a mean FRSs index of 5.6. Fink and Golinkoff have concluded that the DID and schizophrenia comparison groups showed no significant differences regarding mean number of Schneiderian FRSs ($F(1.35)=.72$ $p<.41$). In a similar comparison, Ross et al. (1990) have combined outcome data from several previous studies, and have hypothesized that Schneiderian FRSs are more characteristic of DID than of schizophrenia. The authors report an average of 4.9 FRSs in a series of 368 DID patients, as compared with an average of 1.3 FRSs in a series of 1,739 schizophrenic patients. Other relevant findings by Ross and Joshi (1992) suggest that the presence of Schneiderian FRSs can be correlated both with other clusters of dissociative symptoms, and with a reported history of childhood trauma. According to Ross and Joshi:

> Schneiderian symptoms are linked to other dissociative symptom clusters characteristic of individuals subjected to chronic childhood trauma. If these findings are replicated and accepted, they may lead to a reconceptualization of many "psychotic" symptoms as post-traumatic and dissociative in nature. (Ross & Joshi, 1992, p. 272)

DISSOCIATION AND BLEULER'S CONCEPT OF SCHIZOPHRENIA

Schneider's empirically-derived FRSs initially promised to offer more reliable diagnostic criteria than previously had been offered by Bleuler's original diagnostic schema.

> The concept of specific or pathognomonic symptoms began with Bleuler, who focused on dementia praecox and renamed it schizophrenia. Unlike Kraepelin — who was interested primarily in the objective portrayal of psychopathologic phenomena and generally refrained from speculation about the origin of schizophrenic symptoms — Bleuler devoted himself to understanding the basic mechanisms that caused these symptoms. His search led him to what are now referred to as the four "Bleularian A's" or simply the "four A's" that include associative loosening, affective blunting, autism, and ambivalence. Bleuler worked in an era when association psychology was preeminent. Psychological theorists were preoccupied with determining how thoughts were encoded or formulated in the mind; the prevailing theory was that the process of thinking and remembering was guided by associative links between ideas and concepts. Bleuler believed that the most important deficit in schizophrenia was a disruption in these associative threads. (Andreason & Akiskal, 1983, p. 42)

Bleuler's conceptualization of schizophrenia was influenced by the prevailing association psychology of the era. Bleuler (1911/1950) hypothesized that an underlying process of associative loosening was the fundamental pathognomonic feature of schizophrenia, and he described a variety of dissociative automatisms as primary schizophrenic symptoms. Bleuler listed these symptoms as follows: "Blocking" of movement, speech or thoughts (including various forms of catatonic stupor or negativism); echolalia and echopraxia; thought withdrawal; "made" thoughts, feelings or actions; and "dissociated thinking." Bleuler defined the term "dissociated thinking" as "the disconnecting of ordinarily associated threads in thought and language... [in which] all the association threads fail and the thought chain is totally interrupted." (1950, pp. 21-22).

Bleuler's definitions of the primary dissociative symptoms of schizophrenia bear similarity to Schneider's phenomenological descriptions of the first-rank symptoms. It is

possible that both sets of diagnostic criteria might identify a dissociative symptom cluster which accompanies schizophrenia, but which does not reflect an inherent aspect of the disorder.

Bleuler (1950) outlined his ideas regarding the conceptual relationship between schizophrenia and dissociation in the following manner:

> I call dementia praecox "schizophrenia" because (as I hope to demonstrate) the "splitting" of the different psychic functions is one of its most important characteristics....In every case we are confronted with a more or less clear-cut splitting of the psychic functions. If the disease is marked, the personality loses its unity; at different times, different psychic complexes seem to represent the personality. Integration of different complexes and strivings appears insufficient or even lacking...one set of complexes dominates the personality for a time, while the other groups of ideas or drives are "split off" and seem either partly or completely impotent. (pp. 8-9)

Bleuler's original conception of schizophrenia as a "splitting" of the psyche was influenced by Janet's (1889) concepts of "association" and "dissociation." Bleuler also drew upon Janet's notion of psychasthenia as a basis for his theory about the primary symptoms of schizophrenia.

> Bleuler professed a theory that would be organodynamic today . . . . In the chaos of the manifold symptoms of schizophrenia, he distinguished primary or physiogenic symptoms caused directly by the unknown organic processes [sic], and secondary or psychogenic symptoms deriving from the primary symptoms. This distinction was probably inspired by Janet's concept of psychasthenia. Just as Janet distinguished a basic disturbance in psychasthenia, that is, the lowering of psychological tension, so did Bleuler in much the same way conceive the primary symptoms of schizophrenia to be a loosening of the tension of associations, in a manner more or less similar to what happens in dreams or in daydreams . . . . The autism, that is the loss of contact with reality, was in Bleuler's original concept a consequence of the dissociation. (Ellenberger, 1970, p. 287)

Bleuler also was influenced by Jung's ideas about the role of dissociation in the psychology of dementia praecox. Jung's work had served to integrate the concept of dissociation along with a number of relevant and foundational writings by earlier theorists. According to Jung (1909):

> New and independent views on the psychology of dementia praecox were brought forth by Otto Gross. He proposes the expression dementia sejunctiva for the name of the disease. The reason for this name is the disintegration of consciousness in dementia praecox, hence the sejunction of consciousness. The sejunction concept Gross naturally took from Wernicke. He could just as well have taken the older synonymous idea of dissociation (Binet, Janet). Fundamentally, dissociation of consciousness means the same thing as Gross's disintegration of consciousness . . . . The application made by Gross of this theory of dementia praecox is new and important. Concerning his fundamental idea the author expressed himself as follows: "Disintegration of consciousness in any sense signifies the simultaneous flow of functionally separated series of associations." (p. 23)

A quote from one of Bleuler's (1924) later works illustrates his continuing speculation about the dissociative aspects of schizophrenia: "It is not alone in hysteria that one finds an arrangement of different personalities, one succeeding the other. Through similar mechanisms schizophrenia produces different personalities existing side by side." (p. 138)

It is notable that Jung and Bleuler had based their conceptualizations about dementia praecox and schizophrenia, at least partially, on their respective studies of the famous patient, Daniel Paul Schreber. Schreber had been diagnosed by his doctors, Flechsig and Weber, as suffering from a paranoid psychosis (Lothane, 1992). Jung has offered an interpretation of Schreber's psychotic symptoms in his 1907 publication, *The Psychology of Dementia Praecox.* Although Jung did not specifically address the question of differential diagnosis, the inclusion of Schreber's case history in Jung's book may be interpreted to imply a diagnosis of dementia praecox. Bleuler (1911/1950) also referred to Schreber in his book, *Dementia Praecox or the Group of Schizophrenias.*

> Bleuler was impressed with a number of Schreber's clinical features, which he had classed as schizophrenic, as had already been done by Jung... Bleuler assessed the first episode of illness as a mild schizophrenic episode and the second as an acute protracted episode of catatonia that developed into a chronic paranoid schizophrenic psychosis but not paranoia in Kraepelin's sense. In this, then, Bleuler also rejected Weber's diagnosis. (Lothane, 1992, pp. 323, 345)

A number of contemporary authors have suggested that Schreber's psychiatric symptoms were caused and/or exacerbated by traumatic childhood experiences (deMause, 1987; Goodwin, 1993; Niederland, 1959, 1960, 1974, 1984; Schatzman, 1971; Shengold, 1989; van der Kolk & Kadish, 1987). Lothane (1992) also identifies Schreber's extended involuntary hospitalization as a primary stressor responsible for Schreber's deteriorating psychiatric condition. Lothane additionally draws a parallel between the Schreber case and that of another case history also discussed by Freud.

> Freud's dynamic view of psychosis led him to invoke

> his teacher Meynert's delineation of paranoia as an acute syndrome, Meynert's amentia (Freud, 1911, p. 75). The case Freud (1894) described as Meynert's amentia, or acute hallucinatory paranoia, seemed to resemble Schreber's acute hallucinatory phase .... Meynert's amentia qualifies as a traumatic psychosis .... For Freud, the general idea that psychosis was a defense (thus a neuropsychosis of defense) against a traumatic experience was the dynamic underlying both forms of disorder, hallucinatory confusion, or Meynert's amentia (1894) and paranoia (1896), the former caused by an adult traumatic situation, the latter traced both to infantile seduction and to current conflicts.
> (Lothane, 1992, pp. 330-331)

This type of dynamic viewpoint suggests that acute hallucinatory and delusional symptoms sometimes may accompany the syndrome of traumatic hysterical psychosis. It also raises questions regarding the validity of Jung's and Bleuler's theories on dementia praecox and schizophrenia. In particular, Jung and Bleuler may have neglected to consider the differential diagnosis of hysterical psychosis as relevant to their respective formulations regarding the diagnostic parameters of dementia praecox and schizophrenia.

HYSTERICAL PSYCHOSIS AND SCHIZOPHRENIA

The diagnosis of hysterical psychosis (HP) gained widespread recognition during the nineteenth century; but like the diagnosis of multiple personality disorder, the diagnosis of HP eventually faded from use.

> The concept of hysterical psychosis (HP) suffered a curious fate in the history of psychiatry. During the second half of the 19th century this disorder was well known and thoroughly studied, particularly in French psychiatry. In the early 20th century the diagnosis of hysteria, and of HP, fell into disuse. Patients formerly considered to suffer from HP were diagnosed schizophrenics or malingers. A few clinicians have attempted to reintroduce this diagnostic category, but it has not regained official recognition.
> (van der Hart, Witztum, & Friedman, 1993, p. 44)

The role of traumatically-induced dissociation in the etiology and clinical phenomenology of hysterical psychosis has been recognized by a growing number of contemporary authors, who differentiate this form of psychotic disorder from schizophrenia (Hirsch & Hollender, 1969; Hollender & Hirsch, 1964; Mallett & Gold, 1964; Spiegel & Fink, 1979; Steingard & Frankel, 1985; van der Hart & Spiegel, 1993; van der Hart et al., 1993). Spiegel and Fink (1979) make the following distinctions between the diagnoses of schizophrenia and hysterical psychosis:

> Our thesis is that the phenomena associated with the syndrome of hysterical psychosis may be simplified and understood best by reference to the profound hypnotic trance states of which such individuals are capable. From this point of view such hysterical symptoms as fugue states, amnesia, and hallucinations are understood as spontaneous, undisciplined trance states. Some individuals, in the face of dramatic stress within their family, at their job, or social pressure of other kinds may succumb to a psychotic form of communication which is different from schizophrenia in phenomenology, course, and prognosis. (p. 779)

A number of additional authors concur with this distinction, emphasizing the role of high hypnotizability as an important factor in the differential diagnosis between hysterical psychosis and schizophrenia (Copeland & Kitching, 1937; Gross, 1980; Gruenewald, 1978; Hirsch & Hollender, 1969; Mallet & Gold, 1964; Steingard & Frankel, 1985; D. Spiegel & Greenleaf, 1992; H. Spiegel, 1991; van der Hart & D. Spiegel, 1993; van der Hart et al., 1993). Steingard and Frankel (1985) also discuss the connection between high hypnotizability and dissociation in this clinical population:

> One important mechanism that we believe accounts for one type of transient or recurrent event of psychotic proportions is dissociation. Although the older literature on hypnosis (Janet, 1965) and its history (Ellenberger, 1970) and on dissociation (Nemiah, 1975; Frankel & Orne, 1976) have provided ample evidence of unusual behavior in patients who dissociate easily and, at times, spontaneously, *DSM-III* failed to note the important coexistence of high hypnotizability and dissociative events. (p. 954)

Also supporting this view are van der Hart et al. (1993), who discuss their concerns regarding the confusion in diagnostic nomenclature pertaining to this clinical population:

> The Index of the *DSM-III-R* (American Psychiatric Association, 1987) contains HP, then refers readers to either Brief Reactive Psychosis or to Factitious Disorder with psychological symptoms .... In the case of reactive psychosis, we use the traditional nomenclature of HP in reviewing the literature and propose a new category of psychopathology — Reactive Dissociative Psychosis (RDP). RDP integrates the classical features of HP with the most recent thinking on trauma-induced psychosis.... We believe that the essential characteristic for accurate diagnosis of RDP is not a short duration, but a dissociative foundation....The dissociative foundation of RDP is a more meaningful explanatory principle than an hysterical or histrionic character as currently indicated in *DSM-III-R.* (pp. 44-45, 58)

H. Spiegel (1991) expresses an additional concern: "Without a careful differential diagnosis, hysterical psychosis and mul-

tiple personality disorder are often diagnosed as schizophrenia" (p. 164). As an example, Murray (1993) offers a re-interpretation of the autobiographical account, *I Never Promised You a Rose Garden* (Greenberg, 1964/1981). This classic tale traditionally has been presented as a case study on schizophrenia (Coleman & Broen, 1972). Murray's analysis questions the diagnosis of schizophrenia and focuses on the traumatic origins of the presenting symptomatology. Gainer (1992) similarly focuses on Greenberg's account of childhood trauma, and identifies a number of the heroine's presenting symptoms as characteristic examples of traumatic dissociation.

I Never Promised You a Rose Garden tells the story of a troubled adolescent who is diagnosed with schizophrenia and is hospitalized at an inpatient facility for long-term psychiatric care. Author Joanne Greenberg, who originally published her book under the pseudonym of Hannah Green, has acknowledged the story's parallel with her own real life experiences as a patient under the care of Dr. Freida Fromm-Reichmann, at Chestnut Lodge during the 1940's and 1950's (Goodwin, 1993; Murray, 1993; Rubin, 1972). According to Goodwin: "In those four years of analytic treatment, Fromm-Reichmann and the patient unraveled the connections between these florid symptoms and the extensive medical trauma in early childhood that had schooled Joanne into escapes into fantasy" (Goodwin, 1990, p. 188).

Fromm-Reichmann (1950) has described a case study which bears a strong resemblance to Greenberg's story, and which also illustrates Fromm-Reichmann's approach in treating dissociative symptoms with a traumatic origin.

> Asked if she could remember when being deceived had been linked up for the first time with the ether gun, she immediately recalled an operation which had been performed on her at the age of three. She had been told that it wouldn't be she who would be operated on, but her doll. Ether was the anesthetic used. The ether was administered suddenly while she was still expecting to see what was to be done to her doll. It was as if someone had shot ether at her. Before she was really under, things and people appeared tremendous, and the picture of the doctor who had operated on her had been retained in her memory ever since as that of a giant. Here was deception on the part of both of the patient's parents and of the doctor. It was connected with the sudden experience of the smell of ether imposed on her by a huge man. This, then was the actual experience which gave rise to the hallucinatory repetition of the experience which the patient underwent when she expected to be deceived by the psychiatrist.
> (Fromm-Reichmann, 1950, p. 174)

Fromm-Reichmann conceptualizes in the following manner:

> Descriptively speaking, hallucinations are perceptions without sensory foundation in the environment. Dynamically speaking, they owe their inception to the bursting-through into awareness of certain dissociated impulses which become so overwhelmingly strong that they cannot be retrieved in dissociation.
> (Fromm-Reichmann, 1950, p. 173)

Other related comments by Fromm-Reichmann have unmistakable relevance for contemporary psychotherapeutic work with the DID client:

> The psychoanalyst, as he works with a disturbed schizophrenic, is not only treating a child at different ages but also, and at the same time, an adult person of the chronological age in which he comes into treatment....Psychiatrists who are not sufficiently flexible may find it difficult to address themselves simultaneously to both sides of the schizophrenic personality. They may behave like rigid parents who refuse to realize that their children have grown up. The undesirable results of the psychiatrist's reluctance to communicate with the adult part in the patient's personality and his addressing himself only to the regressive parts in the patient have been discussed before.
>
> If on the other hand, the psychotherapist addresses himself to the adult patient only, out of an erroneous identification with the patient, he renounces comprehension of and alertness to crucial parts of the schizophrenic psychopathology.
> (Fromm-Reichmann, 1948, p. 271)

DISSOCIATION AND PSYCHODYNAMIC TREATMENT APPROACHES TO SCHIZOPHRENIA

Fromm-Reichmann's (1948) approach was influenced by the theoretical work of Paul Federn. Many of Federn's ideas, developed from his studies on schizophrenia, are applicable to the study of dissociative disorders.

Watkins and Watkins (1991) have used Federn's (1943) concept of "ego-states" to develop "ego-state therapy", an approach which has been utilized in the contemporary treatment of DID. Federn (1947b) discusses the concept of ego-states as applied to the treatment of schizophrenia in the following manner:

> One must encourage the patient to recognize how his previous ego-states interfere with his present ones. It is not generally recognized by psychoanalysts that, normally as well as pathologically, ego-states are repressed; successfully in normal people, unsuccessfully in neurotics and in psychopaths. Psychotic patients are able to recognize this fact; frequently they recognize it spontaneously and better than is possible with most healthy persons.
>
> By virtue of the therapeutic influence, favorable cases react in a gratifying manner. By their own repeated attempts the patients learn successfully to

> adhere to the normal adult ego state for periods of increasing length. This concept is similar to that emphasized by Adolph Meyer in his basic goal, the re-integration of the slowly diseased personality. (Federn, 1947b, pp. 130-131)

Federn (1952) hypothesized that psychotic symptoms (such as hallucinations) could result from dissociation which occurred when thoughts were "object cathected," rather than "ego cathected." According to Federn, reduction in "ego cathexis" would result in an analogous loss of reality testing for the psychotic individual. Federn's (1943) descriptions of the complex "split transferences" of the schizophrenic patient also are relevant to the treatment of patients suffering from DID.

> In psychotics, these different ego-states, with their loves and hatreds, are independently organized....Therefore, to use the transference of the psychotic, the analyst has to adjust to the fact that ambivalence is replaced by two (or more) ego-states....The separation of the ego-states remains unconscious in the normal individual and becomes a real split in the psychotic....By the schizophrenic process, previous ego-states temporarily become isolated. Psychoanalysis deals with these states in full acknowledgement of their reality by telling the patient that they are revived child-states of his ego. When we treat a schizophrenic we treat in him several children of several ages.
> (1943, pp. 253-254, 256, 482-483)

Several contemporaries of Federn and Fromm-Reichmann offer additional commentary which is relevant to the treatment of DID, and which predates any modern discussion of DID by approximately 35 years. In 1948, an expert panel on schizophrenia was sponsored by the American Psychoanalytic Association (Cohen, 1948). Members of the panel concentrated their debate on treatment approaches aimed towards the "regressed infant and child" (Rosen, 1947), which seemed to be evident in the psychotic patient. As an example, Rosen's direct psychoanalysis focused upon "...dealing mostly with that level of mentation which occurs in the preverbal period of life and shortly thereafter" (Rosen, 1947, p. 21). Federn comments below on Rosen's methodology:

> His method insists in attacking by direct psychanalytical understanding traumatic events of infancy and childhood, and coping with them as being still there, because there is regression to the ego-states of infancy and childhood. Our optimistic viewpoint assumes that this method removes so much of the cause that a satisfactory maturation of the ego catches up with the previous failures of development and with gaps in integration. Rosen's good results can be explained — without advancing any new theory — by attributing a great traumatic effect to early sex experiences....Rosen's findings revive this etiological factor in psychotic cases.
> (Federn, 1947a, pp. 25-26)

Another central element of Rosen's treatment paradigm is therapeutic "re-parenting." This approach is similar to some of the early, naive treatment approaches utilized in the contemporary treatment of DID, which had been criticized by a number of authors (Greaves, 1988; Kluft, 1985; Putnam, 1989). Other therapists who have developed treatment methodologies utilizing direct re-parenting of schizophrenics have included Laing, best known for his book, *The Divided Self* (1965); and Sechehaye (1951a & b), who pioneered the treatment methodology of "symbolic realization."

In contrast to direct re-parenting, are the "reality based" approaches of Arieti (1974); Fromm-Reichmann (1939, 1943, 1948, 1950); Searles (1959, 1965); and Sullivan (1931-32, 1947, 1962). This school of thought emphasizes therapeutic contact which reinforces the age-appropriate behaviors and responsibilities of the patient, while simultaneously validating the negative impact of past traumatic experiences.

Contemporary therapists can benefit from the wisdom developed by these pioneering therapists. Clinical expertise in the treatment of regressed adult patients has evolved over many years, and is reflective of a growing awareness of the relationship between psychic trauma and the onset of psychiatric symptoms.

As an example, Sullivan (1962) correlates the onset of a schizophrenic youth's acute episode of "catatonic dissociation" with the reawakening of the patient's traumatic memories of childhood sexual abuse. Sullivan discusses his treatment approach with this patient as follows:

> Energy is expended chiefly in reconstructing the actual chronology of the psychosis. All tendencies to "smooth over" the events are discouraged and free-associational technique is introduced at intervals to fill in "failures of memory." The role of significant persons and their doings is emphasized... that however mysteriously the phenomena originated, everything that has befallen him is related to his actual living among a relatively small number of significant people, in a relatively simple course of events. Psychotic phenomena recalled from the more disturbed periods are subjected to study as to their relation to these people.
> (Sullivan, 1962, pp. 277-278)

In another example, Stoller (1973) hypothesized that a dissociative, trauma-based etiology accounted for the auditory hallucinations suffered by one of his schizophrenic patients. Stoller's (1973) book, *Splitting: A Case of Female Masculinity*, chronicles the author's diagnostic and psychotherapeutic explorations with this challenging patient. The book also attempts to clarify the interface between psychosis and dissociative disorders. According to Stoller (1973):

> Discussions of psychological treatments of schizophrenia require that the descriptions of the patients be adequate to differentiate the disorders currently called schizophreniform or reactive schizophrenia or hysterical psychosis — all of which are known to have a good prognosis — from the

fixed and usually incurable schizophrenia.
(Stoller, 1973, p. 318)

Stoller describes his observations of the patient's shifting levels of consciousness in the following manner: "One can watch Mrs. G. slide up and down levels of awareness and move from talking to me in the office to being again back in the past, talking to others whose replies only she can hear" (Stoller, 1973, p. 324).

As the treatment progressed, Stoller had begun to re-evaluate the symptomatic function of his patient's "hallucinatory voices," and to re-evaluate his therapeutic stance in relation to the voices:

> I automatically, as a psychiatrist, I have to be against voices and that's what I've always been; but you're making me think there's something different now for the first time. I'm not sure that I have to destroy it....I'm asking to become acquainted with your voice....Voices have always been to me nothing but sickness. But if I get to know better what your voice really is, I am not sure that I would take the same position....It's possible that the voice is you in the same way as the voices that the rest of us have that we don't hear...but your voice is too separated from the rest of you. You see, I would never think of trying to get rid of your voice...that part of it that's like my voice...I don't want to destroy you. I don't want to destroy that part of you which is your judgment or your conscience. I would hope that the voice would stop making sounds or confusing you or frightening you or threatening you or getting you into trouble, but I don't want to destroy the voice. Because if I understand you right, then I would have to agree with you: To destroy the voice would be to destroy you!
> (Stoller, 1973, pp. 33-34)

Stoller's treatment gradually guided the patient towards an integration of both her personal identity and her emotional well-being. This process included the use of therapeutic trance, recall, and abreaction. Notably, Stoller's therapeutic repertoire foreshadowed the development of many current-day stratagems in the treatment of DID and other dissociative disorders.

Another relevant contribution to the field of dissociative disorders was the development of the "double bind" theory of communication by Bateson, Jackson, Haley, and Weakland (1956). This model was conceptualized as an interpersonal, etiologic model of schizophrenia and was incorporated into the treatment paradigms of Laing (1965); Lidz (1952, 1973); and Searles (1965). In recent years, the double bind model also has proved relevant to the etiologic study of DID (Braun & Sachs, 1985; Fine, 1991; Hughes, 1991; Spiegel, 1986).

A long-term challenge for clinicians in the field of schizophrenia has involved allegations of iatrogenic creation/exacerbation of the disorder (Federn, 1943). Similar concerns currently pose a challenge for clinicians involved in the treatment of dissociative disorders (Braun, 1989; Coions, 1989; Fine, 1989; Greaves, 1989; Kluft, 1989; Torem,1989).

Paul Federn (1943) examines this concern, as related to the treatment of schizophrenia:

> Psychiatrists who disapprove of psychoanalysis never fail to point out those cases in which psychoanalysis, far from having been helpful, created disasters. This statement is both true and false. A series of events does not necessarily represent cause and effect. Many prepsychotic patients come to the psychoanalyst only when they already feel within themselves some uncanny menace of the threatening psychosis. The psychosis would have caught them anyhow with or without psychoanalysis . . . . On the other hand, when psychosis is near the threshold, psychoanalysis breaks down some ego-structures and manifest psychosis results . . . . Psychoanalysis must learn not to provoke latent psychoses, and even more to prevent any psychosis from being the terminal state of a neurosis.
> (Federn, 1943, pp. 12-14)

Federn's comments continue to be very relevant to contemporary practitioners treating individuals diagnosed with DID, and reflect only one aspect of a large heritage of applicable knowledge which has been developed over time by theorists/clinicians working within the field of schizophrenia.

CONTEMPORARY THEORY ON DISSOCIATION AND SCHIZOPHRENIA

Current thinking about the role of dissociation in the development, maintenance, and treatment of psychiatric disturbances continues to evolve and to challenge our traditional ideas regarding disorders such as dissociative identity disorder, schizophrenia, and brief reactive psychosis. In addtion, the current system of diagnostic classification continues to be challenged by the work of contemporary researchers. Newly-proposed diagnostic schemas currently include the categories of reactive dissociative psychosis (van der Hart et al., 1993) and of a dissociative type of schizophrenia (Ross, Anderson, & Clark, 1994).

The latter authors present data suggesting that "there may be two pathways to positive symptoms of schizophrenia, a childhood trauma pathway and a biological disease pathway" (Ross et al., 1994, p.2). Bellak, Kay, and Opler (1987) have provided an historical precedent for this kind of diagnostic subtyping via their proposal of an attention deficit disorder psychosis. This diagnostic subtype is differntiated clearly by Bellak et al. (1987) from any of the existing subgroupings within the traditional schizophrenic matrix, and may serve as a useful model for the study.

In further discussion on this topic, Bellak (1994) quotes a relevant passage by R.W. Heinricks:

> The failure to achieve a rigorous grasp of the heterogeneity problem has created an uncertainty that hinders schizophrenia research at all levels . . . . The likelihood that researchers are studying different illnesses without being able to specify these differences must be recognized as the superordinate problem. It is not a subproblem which can be ignored. It is the major obstacle to scientific progress. (Heinrichs, cited in Bellak, 1994, p. 27)

In summary, consideration from an historical perspective suggests that continued collaboration by mental health practitioners across specialized fields of endeavor can yield significant contributions to our basic knowledge regarding the role of dissociation in mental functioning. ■

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